

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Moonlight Vista	CHAPTER 100.1
Address: 98-1282 Ho`ohuali Place, Pearl City, Hawaii 96782	Inspection Date: February 7, 2019

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b><u>FINDINGS</u></b> No record of negative subsequent chest x-ray following positive skin test in 2000.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> Negative chest x-ray available in record for SCG, however, no evidence of history of positive PPD result</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><b><u>FINDINGS</u></b> No evidence of SCG training in record.</p>	<p><b>PART 1</b></p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	



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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> For Resident #1 – “Clopidogrel 75mg tab, take 1 tab by mouth once daily (start 1/11/19)” ordered on 1/10/19. Medication Administration Record indicates that Resident #1 received medication on 1/10/19.</p>	<p><b>PART 1</b></p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(2)(D) Residents' rights and responsibilities:</p> <p>Each resident shall:</p> <p>Physical restraints may only be used in an emergency when necessary to protect the resident from injury to self or to others. In such a situation the resident's physician or APRN shall be notified immediately to obtain an assessment for least restrictive alternatives to restraint use. If restraint use is determined to be necessary, written orders shall be obtained from the resident's physician or APRN indicating the form of restraint to be used, the length of time restraint shall be applied, the frequency of use and the alternative care that can be provided to the resident. If a less restrictive alternative to restraint exists, it must be used in lieu of the restraint. The resident's family, legal guardian, surrogate or representative, and case manager shall be notified if no alternative to restraint exists and a written consent shall be obtained for restraint use. The restraint use shall be in compliance with the Type I ARCH's written policy, as approved by the department;</p> <p><b><u>FINDINGS</u></b> Resident #1 – “Side rails” ordered by Physician on 1/10/19 however, order does not indicate required parameters for use.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_